UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

TRACLEER (bosentan)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Extensions and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Age limit: 13 and above
- Documented WHO (World Health Organization)diagnosis of class III or IV Pulmonary Arterial Hypertension
- Copy of prescription from physician.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.

INFORMATION:

- Contraindicated for patients with moderate to severe liver impairment and patients taking cyclosporine or glyburide
- Females can not be capable of becoming pregnant.
- Dose**:** 62.5mg b.i.d. for 4 weeks, then increased to 125mg b.i.d. (Maximum)